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CHAPTER I: OVERVIEW OF OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

OBJECTIVE

This chapter provides participants with an overview of the outpatient prospective payment system. It also introduces terminology and concepts that will facilitate understanding of the detailed discussion in later chapters.

Effective with services on or after July 1, 2000

OVERVIEW

Effective for claims with dates of service on or after July 1, 2000, Medicare implements the outpatient prospective payment system (OPPS). OPPS applies to hospital outpatient departments, community mental health centers (CMHCs) and for some services provided by comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs) and services provided to hospice patients for the treatment of a non-terminal illness. The 10 cancer centers exempt from inpatient PPS are included in OPPS.

OPPS does not apply to Indian Health Service, Critical Access Hospitals, or Maryland Hospitals

OPPS does not apply to Indian Health Service or critical access hospitals. Hospital outpatient services furnished by Maryland hospitals are under a waiver and will not be paid under this system.

Payment under OPPS will result in the discontinuation of the blended payment methodology for outpatient radiology, outpatient other diagnostic, and outpatient ambulatory surgical center (ASC) services.

BACKGROUND

HCFA is authorized to implement a Medicare prospective payment system for certain types of services.

BBA-97

The Balanced Budget Act (BBA-97) of 1997 required HCFA to implement a Medicare prospective payment system for the following types of services:

- Hospital outpatient services, including partial hospitalization services
- Certain Part B services furnished to inpatients who have no Part A coverage

- Partial hospitalization services furnished by community mental health centers (CMHCs)

- Vaccines, splints, casts and antigens provided by home health agencies (HHAs) that provide medical and other health services

- Vaccines provided by comprehensive outpatient rehabilitation facilities (CORFs)

- Vaccines, splints, casts and antigens provided to hospice patients for the treatment of a non-terminal illness.

BBA-97 authorized HCFA to develop a classification system consisting of groups of services so that services within each group are comparable clinically and with respect to the use of resources. HCFA will establish relative payment weights for each group based on median hospital costs and estimated frequencies of utilization of services in 1999. The BBA-97 further provided that HCFA will also establish a wage adjustment factor and may establish other adjustments determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals.

Calculation of Fee Schedule Amounts

BBA-97 provided that the outpatient hospital payment rate amounts in 1999 would be determined in the following way:

- HCFA will estimate the sum of: (1) the total amount that would otherwise be paid by Medicare for outpatient hospital services in 1999; and (2) the total amount of copayments that are estimated to be paid under the pre-PPS payment system in 1999, as described below.

- A conversion factor is estimated in order to convert the weights into fee schedule amounts. This conversion factor is calculated in a manner so that the sum of the products of the fee schedule amounts and the frequencies equals the aggregate sum of Medicare payments and copayments estimated above. [Note: Since the formula-driven

overpayment is eliminated on October 1, 1997 and the cost and capital reductions on outpatient hospital services are being extended, these two provisions are built into the base outpatient hospital fee schedule rates in 1999.

- For each group, the outpatient hospital fee schedule amount is equal to the conversion factor multiplied by the weight.

Calculation of:

- **Coinsurance Amount**
-
- **Minimum Coinsurance Amount**
-
- **Pre-deductible Payment Percentage**

- **Medicare Payments and Coinsurance**

A coinsurance amount (unadjusted coinsurance amount) is established for each outpatient hospital payment group based on 20 percent of the national median of the charges for services in the group furnished during 1996, updated to 1999 using HCFA's estimate of charge growth. A minimum coinsurance amount (floor) is established based on 20 percent of the outpatient payment rate amount. The unadjusted coinsurance amount for an outpatient hospital payment group cannot be less than 20 percent of the payment rate for the payment group.

A pre-deductible payment percentage will be calculated for each group in each year. This will be equal to the ratio of: the outpatient hospital payment group's rate minus the unadjusted copayment amount over the payment group's payment rate.

To determine payment for a particular group in a particular area, the following calculation will occur:

1. The payment rate for the outpatient hospital payment group will be adjusted by the wage adjustment factor and other factors determined to be necessary by the Secretary.

2. The Medicare portion of the outpatient hospital payment group's rate will be equal to the adjusted payment rate, reduced by any unmet deductible amount, multiplied by the pre-deductible payment percentage.

3. The amount of beneficiary copayment will be equal to the adjusted outpatient hospital payment rate

amount in step1 minus the Medicare portion of the payment calculated in step 2.

Calculation of payments in subsequent years

In future years, the conversion factor used to determine the outpatient hospital payment rates will be updated by the hospital market basket, except that for 2000, 2001, and 2002, the update will be equal to the hospital market basket reduced by 1 percentage point.

Coinsurance Ceiling Eventually Equal to 20% of OPD Fee Schedule

In each year, the unadjusted copayment amount remains unchanged until the coinsurance amount becomes equal to 20 percent of the outpatient hospital payment group's rate. The pre-deductible payment percentage and the Medicare payment, however, will continue to be calculated in the same manner, and Medicare will assume a larger portion of the total outpatient payment rate each year. At the point in time when the coinsurance amount for a group equals 20 percent of the payment rate, the copayment amount will be maintained each year at 20 percent of the group's payment rate.

Election to Offer Reduced Coinsurance Amount

BBA-97 required HCFA to establish a procedure whereby a hospital could elect to reduce the coinsurance amount for some or all outpatient services to a lower amount (but not less than 20 percent of the group's payment rate).

Periodic Review and Adjustment to PPS

The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. Such adjustments must be made in a budget neutral fashion.

Volume Adjustment

The Secretary is required to develop a method for controlling unnecessary increases in the volume of services. If the Secretary determines under such a methodology that the volume of services has increased beyond reasonable amounts established through such methodology, the Secretary may adjust the update to the conversion factor. (Note: At this point, HCFA has delayed implementation of a volume control mechanism.)

Limitation on Review

There shall be no administrative or judicial review of the development of the classification system, including the establishment of groups and relative payment weights, wage adjustment factors, other adjustments, and volume performance methodologies, the calculation of base amounts, periodic adjustments, and the establishment of a separate conversion factor for cancer hospitals.

BBRA-99

The Balanced Budget Refinement Act of 1999 (BBRA) contained the following major provisions that affected the development and implementation of OPPS:

Outlier Payments

- Outlier payments to cover some of the additional cost of providing care that exceeds established thresholds
- Payments under OPPS must be budget neutral to the payments that hospitals receive currently
- Extension of the 5.8 percent reduction in outpatient operating costs and 10 percent reduction in outpatient capital costs through the first date that OPPS is implemented
- Annual updating of the OPPS payment weights, rates, payment adjustments and groups
- Annual consultation with an expert provider advisory panel for the review and updating of payment groups
- Budget neutral outlier adjustments based on charges adjusted to cost for all OPPS services included on the submitted outpatient bill for services furnished before January 1, 2002. Services furnished on or after January 1, 2002 will be based on the individual services billed

Transitional Pass-Through Payments

- Transitional pass-through payments for the additional costs of new and current medical devices, drugs, and biologicals for at least 2 years but not more than 3 years
- OPPS payments for implant devices including Durable Medical Equipment (DME), prosthetics and those used in diagnostic testing

Transitional Corridor Payments

- Transitional corridor payments to limit hospital and CMHC losses under OPPS; the additional payments for 3.5 years for most hospital facilities including rural hospitals (less than 101 beds), and permanent for the 10 cancer hospitals
- Beneficiary coinsurance for individual services paid under OPPS limited to the inpatient hospital deductible amount for each APC

HCFA has determined that certain services will continue to be paid based on their respective fee schedules

BBA-97 grants HCFA the authority to determine which services are included (with the exception of ambulance services for which a fee schedule is being separately created) in OPPS. HCFA has determined that the following services will continue to be paid based on their respective fee schedules:

- Clinical diagnostic laboratory services
- Orthotics, prosthetics (except as noted above)
- Take-home surgical dressings
- Chronic dialysis (using the composite rate)
  Note: Acute dialysis, e.g., for poisoning, will be paid under OPPS
- Screening mammographies (based on the current payment limitation)
- Outpatient rehabilitation services (physical therapy including speech language pathology and occupational therapy) under the Medicare Physician Fee Schedule.
- Corneal tissue will be paid on cost basis

Note: The final rule implementing OPPS was published in the *Federal Register* on April 7, 2000 and is available on the HCFA web site (www.hcfa.gov/regs/hopps/). The text from the final rule has also been included in the appendix section of this document.

AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS

OPPS will consist of groups of services known as Ambulatory Payment Classification (APC) groups

OPPS will consist of groups of services known as Ambulatory Payment Classification (APC) groups. Services within an APC are similar clinically and require similar resource use. APCs require no changes to the billing form; however, hospitals are required to include HCPCS codes for all services in order to be paid accurately under OPPS.

APC payment rates were calculated in the following manner:

APC payment rates calculated based on 1996 claims

- Each APC group's relative weight was calculated based on the median cost (operating and capital) of the services included in the group.
- Median costs were developed from a database of CY96 hospital outpatient claims using "the most recent" cost report data available.
- Hospital-specific and department-specific cost-to-charge ratios were used to convert billed charges to median costs for each group.
- Weights were converted to payment rates using a conversion factor, which takes into account group weights, the volume of services for each group, and an expenditure target specified in the law.

APC payments adjusted for budget neutrality

- Hospital outpatient payments that would have been effective in CY99 were calculated on a budget neutral basis to equal projected 1999 payments to hospitals for services included under the OPPS.

The rates that will be effective when OPPS is implemented will be the 1999 rates updated by the hospital market basket minus one percent.

APC Packaging

APC packaging will occur in the following manner:

- Initially, there will be only minimal packaging, i.e., payment for a procedure or medical visit will not include payment for the related ancillary services such as laboratory tests or x-rays.

- For example, payment for clinical diagnostic laboratory tests paid under the clinical diagnostic fee schedule and radiology services paid under OPPS will be made in addition to the OPPS payment for a surgical procedure or medical visit.

- APC payments will include certain packaged items, such as anesthesia, supplies, certain drugs and the use of recovery and observation rooms.

APC Discounting

Multiple APC surgical procedures furnished during the same operative session will be discounted. Discounting will be performed in following manner:

- The full amount is paid for the procedure with highest weight; 50 percent is paid for any other-procedure(s) performed at the same time.

  Similar discounting occurs now under the physician fee schedule and under the payment system for ambulatory surgical centers.

- Surgical procedures terminated after patient is prepared for surgery but before induction of anesthesia will be paid at 50 percent of the APC payment.

- Beneficiary coinsurance will be similarly reduced when multiple surgical procedures are performed.

APC payments adjusted for geographic differences

BBA-97 requires APC payments to be adjusted to reflect geographic differences in labor-related costs.

- Adjustments for differences in wages across geographic areas using inpatient hospital PPS wage index (post-reclassification, post-floor) will be made.

- 60 percent of the APC payment rate is considered to represent labor-related costs and will be subject to the geographic adjustment.

HCFA must update payment rates annually

BBA-97 requires HCFA to update payment rates annually based on the hospital market basket less one percent for the years 2000 through 2002.

New outpatient procedures and services will be added to the payment system as needed and weights will be adjusted to reflect changes in outpatient care.